

Registration District No. 318

Primary Registration District No. 5439

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Springfield Route #2 Campbell Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 91 years (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Mary Frances Drumright
3. (b) If veteran, name war _____ 3. (c) Social Security No. 6510

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife George W. Drumright 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 9 1848
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
=	91	4	23	hr. min.

9. Birthplace Green Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home mother

11. Industry or business _____
MOTHER FATHER {
12. Name James Reese
13. Birthplace Chickasaw Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name No record
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Frances Drumright
(b) Address Rt 2 Box 125

17. (a) Burial (b) Date thereof Jan 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery

18. (a) Signature of funeral director Fred C. Thome
(b) Address 1100 Bronzella Ave

19. (a) 1/2/40 (b) Geo. B. George
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Springfield Route # 2
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2nd
year 1940 hour 12:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw her alive on Sept 10 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Due to Advanced age
and poor breakdown

Due to _____
Other conditions 16
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy no

22. If death was due to external causes, fill in the following: _____

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
none
While at work? none (Specify type of place) (e) Means of injury _____

23. Signature S. F. Freeman (M. D. or other) _____
Address Springfield Mo Date signed 1-2-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X 1931

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision. *Self*

Signed *RH Thorne*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X